# MODULE 3: INTERVENTIONS/SERVICES

*Do you take the pictures down? Do you get rid of their clothes and toys? What do you do when people ask 'Do you have children?' I don't have any answers.*

—Edye Smith, Mother of Chase, 3, and Colton, 2, who were killed in bombing of the Alfred P. Murrah Building, Oklahoma City, Oklahoma, April 19, 1995[7]

The field of disaster mental health services is continuously evolving as new experiences provide additional evidence. While there are still gaps in the research on the effectiveness of early interventions, much research has been conducted on the effectiveness of intervention approaches and a range of services have been found to be appropriate. Disaster mental health experts and practitioners agree there is no one best mental health intervention; the interventions must be tailored to the unique experiences and the needs of the affected individuals and community. This is especially true when it comes to response to terrorism, where no two events are ever the same.

Experienced emergency services workers may already be familiar with much of the material presented here. New aspects may be the context in which these services are provided, the populations served, as well as the approach of assisting the community with a model based not on pathology but on a wide range of natural responses.

*As a clinician, I think the most important thing is that one should not expect that, simply because one has a degree in mental health services, one can do trauma work. It really takes a little bit, not a lot, but some special training to provide these services to the public in an ethical way and in a way that is beneficial to recovery.*

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

Disaster mental health assistance needs to be practical, flexible, empowering, and reflect survivors' needs to pace their exposure to harsh realities resulting from the event. While most survivors will experience normal traumatic stress and grief reactions, a significant minority will experience serious longer-term psychological difficulties. To make appropriate decisions about service provision, it is important to understand the range of reactions. The overwhelming fear associated with terrorism affects the services utilized and the way they are provided.

A variety of mental health interventions have been identified as common and accepted approaches during a terrorist event response. Deciding which approaches are used will depend upon the phase of recovery from terrorism (see Module 2, Table 2–1). For example, during the impact phase, immediately after a disaster, the focus might be on psychological first aid, whereas psychoeducational approaches may be more beneficial during the phases of reconstruction and working through grief. Some possible approaches include:

[7] (1995). Requiem for the heartland the Oklahoma City bombing. San Francisco: The Tides Foundation and Collins Publisher.

- Psychological first aid
- Crisis intervention
- Informational briefings
- Psychological debriefing
- Psychoeducation
- Community outreach
- Brief counseling interventions
- Support and therapy groups
- Mental health consultation
- Support role during death notification

After completing this module,[8] a disaster mental health worker will be able to:

- Identify common and more problematic reactions to terrorist events
- Understand the key principles of disaster mental health response
- Identify interventions that are appropriate following a terrorist event

## Reactions to Terrorist Events

Most people experience typical reactions to terrorism and traumatic events. It is critical to reassure survivors that their reactions are normal, regardless of how they may feel. Terrorism and traumatic events activate the body's survival response, i.e., fight, flight, freeze. As this response unfolds, people behave in a variety of ways and have a wide range of experiences. For most people, the return from crisis to everyday functioning is an automatic process requiring little or no intervention. It is important to understand when to simply allow the process to unfold naturally, when to intervene, and when to refer.

[8]Much of the information is adapted from DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Dr. Deborah DeWolfe, a veteran disaster mental health worker, interviewed disaster mental health workers from across the country and studied current research and literature to determine what were the common and accepted best practices. Community Resilience Project staff added to this material from their experiences in responding to 9/11.

## *Common Reactions to Trauma*

The following chart organizes, by age, typical cognitive, behavioral, physical, and emotional reactions to traumatic events.

*All Ages*

- ❑ Anger
- ❑ Anxiety
- ❑ Appetite changes
- ❑ Colds or flu-like symptoms
- ❑ Concentration problems
- ❑ Fear of crowds or strangers
- ❑ Fear of darkness
- ❑ Feelings of hopelessness
- ❑ Guilt
- ❑ Headaches
- ❑ Mood-swings
- ❑ Nausea/stomach problems
- ❑ Nightmares
- ❑ Poor work performance
- ❑ Confusion
- ❑ Crying easily
- ❑ Denial
- ❑ Fatigue
- ❑ Fear of being left alone
- ❑ Hyperactivity
- ❑ Hyperviligence/increased watchfulness
- ❑ Increased drug and alcohol use
- ❑ Irritability
- ❑ Isolation
- ❑ Reluctance to leave home or loved ones
- ❑ Sadness
- ❑ Sensitivity to loud noises
- ❑ Sleep difficulties

*Children of All Ages*

- ❑ Anxiety and irritability
- ❑ Clinging, fear of strangers
- ❑ Fear of separation, being alone
- ❑ Head, stomach, or other aches
- ❑ Increased shyness or aggressiveness
- ❑ Nervousness about the future
- ❑ Regression to immature behavior
- ❑ Reluctance to go to school
- ❑ Sadness and crying
- ❑ Withdrawal
- ❑ Worry, nightmares

*Preschool Age (1–5)*

- ❑ Changes in eating habits
- ❑ Changes in sleeping habits
- ❑ Clinging to parent
- ❑ Disobedience
- ❑ Fear of animals, the dark, "monsters"
- ❑ Hyperactivity
- ❑ Speech difficulties
- ❑ Regression to earlier behavior (thumbsucking, bedwetting)

*Early Childhood (5–11)*

- ❑ Increased aggressiveness
- ❑ Changes in eating/sleeping habits
- ❑ Difficulty concentrating
- ❑ Regression to earlier behavior
- ❑ Competing more for the attention of parents
- ❑ Fear of going to school, the dark, "monsters"
- ❑ Drop in school performance
- ❑ Desire to sleep with parents

*Adolescence (12–14)*

- ❑ Abandonment of chores, schoolwork, and other responsibilities previously handled
- ❑ Disruptiveness at home or in the classroom
- ❑ Experimentation with high-risk behaviors such as drinking or drug abuse
- ❑ Vigorous competition for attention from parents and teachers
- ❑ Resisting authority

*Problematic Reactions*

The following may indicate the need for more extensive intervention and counseling:

- ❑ Disorientation—dazed; memory loss; inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening
- ❑ Inability to care for self—not eating, bathing, or changing clothes; inability to manage activities of daily living
- ❑ Suicidal or homicidal thoughts or plans
- ❑ Problematic use of alcohol or drugs
- ❑ Domestic violence, child abuse, or elder abuse
- ❑ Any common reaction may require intervention if it interferes with daily functioning

**Risk Factors for Problematic Reactions to Trauma**[9]

The following are risk factors at different stages of a terrorist event that may help identify individuals and groups who are more susceptible to having a more problematic stress response. Additional, immediate outreach and intervention efforts may be needed in these situations.

*Personal Risk Factors Before Trauma*

- Past history of Posttraumatic Stress Disorder (PSTD)
- History of childhood abuse
- Early attachment issues
- Family history of trauma
- Psychological difficulties
- History of substance abuse
- Female gender
- Younger age
- Low socioeconomic status
- Lower intelligence

*Personal Risk Factors During Trauma and 24 Hours After Trauma*

- Degree and intensity of exposure
- Dissociation
- Intrusion and avoidance
- Depression
- Hyperarousal
- Negative self-talk
- Lack of immediate social support

[9] Adapted from presentations made by Dr. Rony Berger, Psy.D., at Natal Israel Trauma Center for Victims of Terror and War, on June 11 and 12, 2002.

*Personal Risk Factors After Trauma*

- Lack of societal acknowledgment
- Lack of ongoing social support
- Stressful life events
- Unproductive family patterns

*One of the things that we've seen, and this is consistent in our work with individuals and groups, is that people are sensing greater anxiety, which manifests in many ways, in terms of physical symptoms, not feeling well, headaches, tension…It's pervasive. I think that everywhere we go in the Washington area, people are living with a sense of still feeling hyper-alert.*

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

*Dynamics of Symptoms Over Time*

Post-event traumatic reactions may be:

- Intense or mild
- Immediate or delayed
- Cumulative in intensity
- Reactivated by:
  - Subsequent traumatic experiences
  - Reminders of the event:
    - Anniversaries
    - Area or object associated with the event (e.g., planes, building)

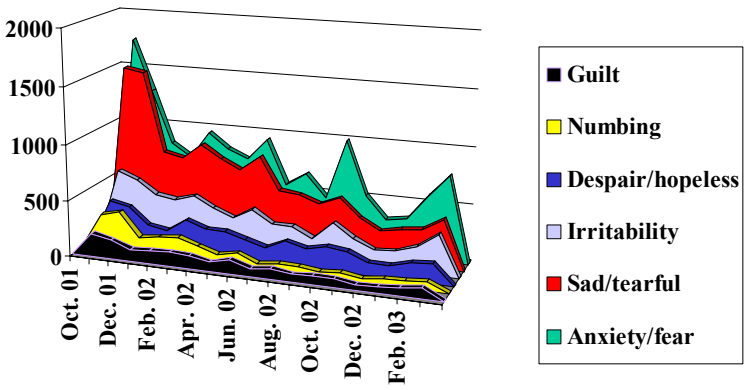
Symptoms may also be activated by vicarious trauma, such as media exposure or contact with people involved in the terrorist event.

**Patterns of Reactions in Northern Virginia After 9/11**

The following charts demonstrate the pattern of reactions experienced in Northern Virginia by people who received individual crisis counseling services from the Community Resilience Project during the 18-month period following 9/11. Each chart shows the number of people experiencing or exhibiting the described reactions. During that time period, Northern Virginians experienced the anthrax attack, sniper attacks, terrorist alerts, and the war on terror. Each new event created a surge in reactions and services. The peaks in reactions around October 2002, for example, were in response to the sniper attacks, and in March 2003, to the heightened security alerts followed by the war on terror. Each of these events contributed to fear and anxiety, and created hypervigilance throughout the community. A number of the sniper attacks occurred in shopping areas and gas stations. In an attempt to make it difficult to be shot, people were doing what was referred to as the "bob and weave" while walking to the shopping center or were crouching beside their car while pumping gas. Thus, the chart displays a peak in hypervigilance at this time.

Using a medical metaphor, the healing process was not progressing in the community as anticipated post-9/11 because the "scab" had not been allowed to fully form and heal. Not only did these events evoke trauma in the region, but people responded to the government and media reports as though the next terrorist event was just around the corner. Reminders were everywhere, such as digital warning signs posted above interstate highways that read: "Report Suspected Terrorism 1-866-XXX-XXXX"

Community Resilience Project of Northern Virginia
COMING TOGETHER TO HEAL



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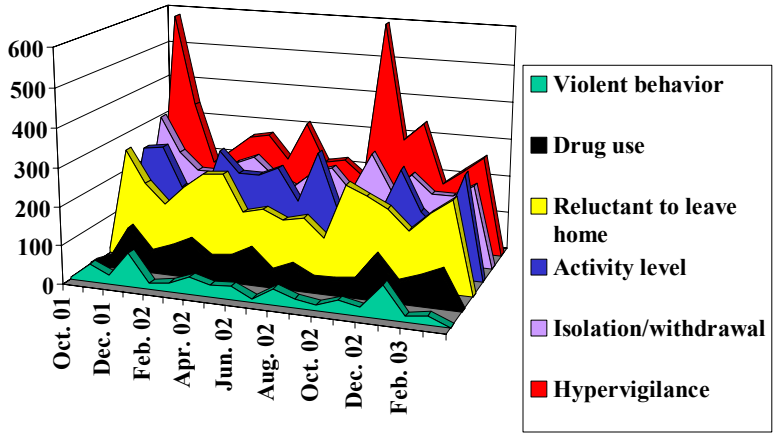
## Behavioral Reactions

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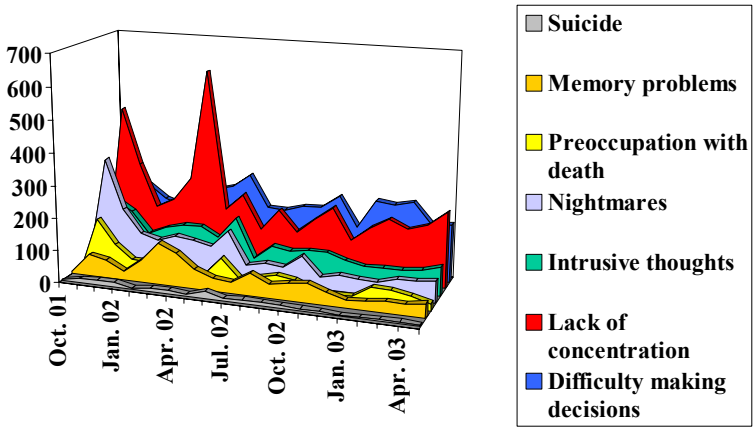
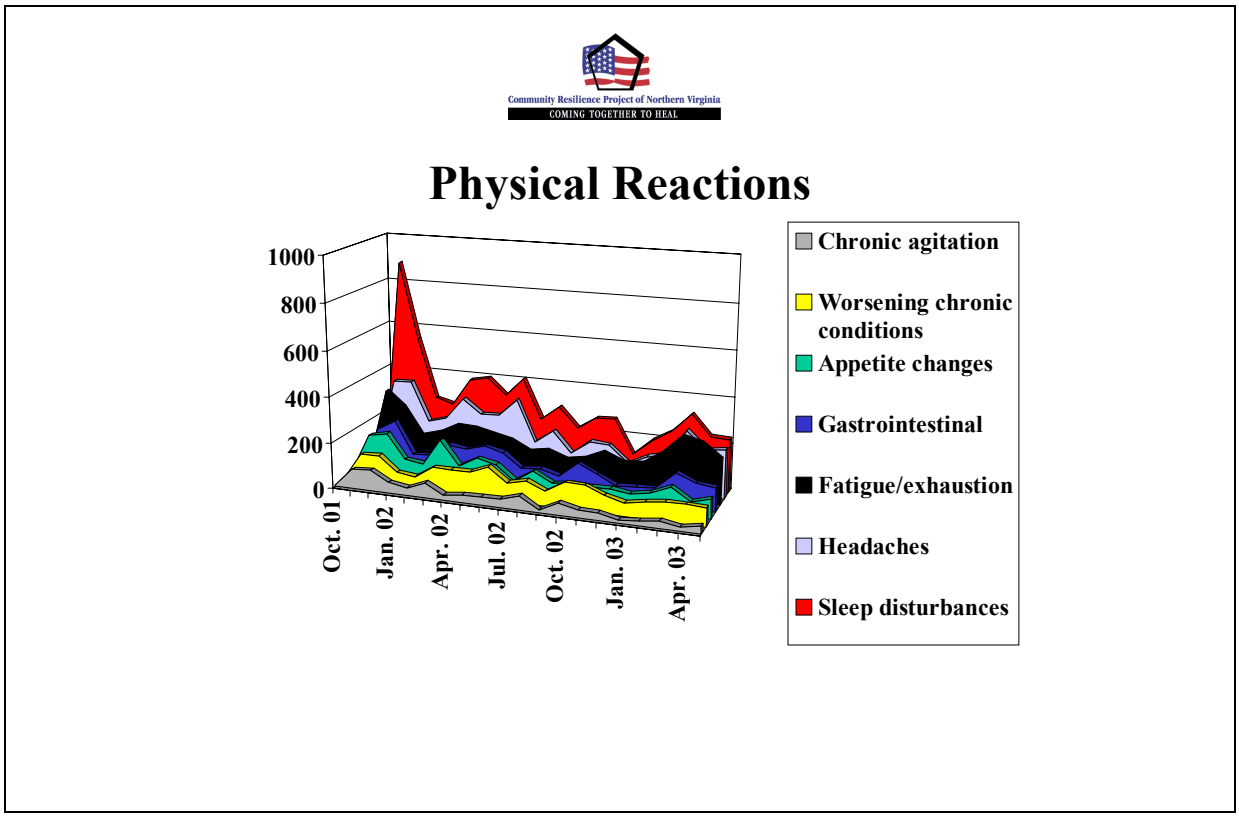
## Cognitive Reactions






## Key Principles for Disaster Mental Health Intervention

1. **Do no harm.** First and foremost, mental health workers must assess an individual's needs with great sensitivity. Accepting and validating a person's reactions in the moment are critical to avoid disruption of the natural healing process. When in doubt about the level of intervention, err on the side of caution.

2. **Assume resilience.** Human beings are very resilient. The goal of disaster mental health intervention is to support and empower people as they access the strengths and coping mechanisms that have given them strength and comfort in the past. For example, assisting individuals in connecting with family or other existing support networks can help them cope with the effects of the trauma.

3. **Everyone who experiences a terrorist event is affected by it.** A terrorist event has far-reaching implications. People may be directly affected by being at the site or by losing a loved one. They may also be indirectly affected by exposure to media, hearing someone's story, reactivation of past trauma, or the ripple effect (such as economic impact).

4. **Simple human presence is powerful and reassuring.** Providing emotional safety by being quietly present can be valuable following exposure to trauma. Mental health services following a terrorist event are aimed at acknowledging health and normalizing individual responses versus actively seeking out pathological reactions. Simply being present with people may initially seem insufficient or less important than traditional mental health therapy, yet this service can do much to minimize long-term traumatization.

5. **Be culturally competent.** Having knowledge and awareness of the diversity that exists within the community one intends to serve is crucial. To provide competent services as a mental health worker, it is important to educate oneself regarding each individual's cultural history, norms, values, belief systems, language, traditions, and view of the trauma/grieving processes. In addition, mental health workers need to explore and understand their own backgrounds, biases, and value systems. This exploration is important to ensure that mental health workers are comfortable with different points of view and are able to provide nonjudgmental services.

6. **Terrorist attacks affect both individuals and communities.** In some cases, the effect can be positive and empowering, as community members realize they can join together to cope effectively with difficulties. Terrorist attacks can negatively affect the functioning of social institutions, which, in turn, can interfere with individual recovery. Facilitating the recovery of the community as a whole affects the individual's ability to heal. The dynamics of this process will vary with the particular nature of the disaster. Certain groups may become scapegoats or be targeted for victimization, thereby affecting overall community functioning.

7. **Respect individual differences in moving through traumatic reactions.** Every individual has his or her own process of recovery that may be appropriate for that person. Some people may not exhibit traumatic reactions initially and may remain in a state of immobility or denial for a longer period of time. Accepting and respecting a person's pace of progress is crucial. It is to be expected that, at any point, some people may reject services and this may be a healthy response to their individual needs. In some cases, on the other hand, symptoms may not arise for months or years after an event.

8. **Services are enhanced by a flexible approach that includes ongoing assessment, evaluation, and revision.** Each community has unique requirements that can be discovered only through accurate assessment. In addition, needs for services change as recovery progresses. Creativity, responsiveness, and flexibility are key elements to effective service delivery.

9. **Development of a team approach is vital to effective functioning.** People on the disaster mental health team bring a variety of perspectives and points of view that, as a whole, reflect the community they serve. This variety allows the team to better assess the needs of the community as it moves through the process of recovery. In addition, people bring different talents to disaster recovery planning. Members of a team can be mutually supportive in maintaining optimal functioning, motivation, and direction as well as in addressing issues of vicarious trauma.

10. **Mental health services must be coordinated with the larger response-recovery team which may include fire, police, rescue, and recovery agencies**. Mental health workers have an important role to support the first responders and provide immediate services to victims when appropriate. The coordination of mental health response with other agencies in an emergency situation is essential. Efforts to organize these services need to be addressed in most communities. If the response and relief agencies fail to coordinate efforts, they can frustrate or anger the survivors. Coordinating mental health services with the agencies involved in these processes is important to helping survivors cope.

## Range of Interventions/Services[10]

At different phases of the post-disaster environment, various types of interventions will be appropriate. The following information provides guidance on the appropriate range of services for use with adults, older adolescents, and older adults.

At the scene of a terrorist event, facilitating physical and emotional safety is the primary objective. A common response of many survivors is to feel highly vulnerable and fearful; therefore, interventions emphasize protection and safety as well as promote a sense of security. The four initial intervention goals are:

- Identify those in need of immediate medical attention
- Provide supportive assistance and protection from harm
- Facilitate connecting survivors with family and friends
- Provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts

Once safety is established, the following four intervention goals should be targeted:

- Alleviate distress through supportive listening, providing comfort, and empathy
- Facilitate effective problem-solving of immediate concerns
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor
- Provide psychoeducational information regarding post-trauma reactions and coping strategies

## *Psychological First Aid*[11]

Rapid assessment is conducted to identify the survivors who are most acutely distressed and in need of medical attention. Initially, triage decisions are based on observable and apparent data. Persons experiencing physiological reactions like shaking, screaming, or disorientation may need to receive emergency medical attention. Medical assessment and assistance are necessary for older adult survivors who are vulnerable because of health conditions and physical or cognitive limitations. People who appear profoundly shut down, numb, dissociated, and disconnected may also require medical attention.

Psychological first aid involves three basic concepts: protect, direct, and connect.

[10] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[11] Ibid.

- Survivors need to be **protected** from viewing additional traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.

- When disoriented or in shock, survivors need to be **directed** away from the trauma scene and danger, and into a safe and protected environment. A brief human connection with a disaster mental health worker can help to orient and calm them.

- Disaster mental health workers assist survivors by **connecting** them with loved ones, as well as with needed information and sources.

Psychological support involves:

- Addressing immediate physical necessities

- Comforting and consoling the survivor

- Providing concrete information about what will happen next, thus increasing a sense of control

- Listening to and validating feelings

- Linking the survivor to support systems

- Normalizing stress reactions to trauma and sudden loss

- Reinforcing positive coping strengths

- Facilitating some telling of the "trauma story," as appropriate for the survivor

- Supporting reality-based, practical tasks

## *Crisis Intervention*[12]

While sharing elements of psychological first aid, crisis intervention aims to empower survivors so that they may effectively address immediate challenges. Crisis intervention typically involves five components:

- Promote safety and security

- Invite the person to share their experience

- Identify current priority needs, problems, and possible solutions

- Assess functioning and coping

- Provide reassurance, normalization, psychoeducation, and practical assistance

[12] Ibid.

**Promote safety and security.** Survivors need to feel protected from threat and danger. When given simple choices, many come to feel empowered as they exercise some control over their situations—a critical step for engaging initial coping and internal organization. For example, ask:

- *May I get you something to drink?*
- *Are you feeling comfortable/safe here?*

**Invite the person to share his or her experience.** For many, verbalizing emotions, reactions, and experiences is therapeutic and an important step toward coping with the situation. Ask the individual:

- *If you want to talk about what happened, I would like to listen.*
- *Where were you when it happened?*
- *How have you been reacting and feeling?*

For those who are highly distressed, however, talking in much detail about their disaster experience and expressing related emotions might be retraumatizing. People may not be ready to express their emotional reactions. Just being with someone can be a great comfort.

If the person is able, provide reassurance and comfort, and move on to problem-solving. Often, practical matters need to be addressed. For example, someone may need to notify relatives and friends of the loss of a loved one, fill out insurance forms, pay bills, or notify his or her employer that he or she will need to be on leave of absence for a period of time. Disaster mental health workers can help the person to begin to prioritize and problem-solve the many practical decisions that need to be made.

**Identify current priority needs, problems, and possible solutions.** Selecting one solvable problem as most immediate and addressing it successfully can help to bring back a sense of control and capability. Identifying potential sources of support among friends, family, faith organizations, health care providers, or the community may be helpful. Probes might include:

- *Describe the problems/challenges that you are facing now.*
- *Who might be able to help you with this problem?*
- *What has helped you in the past work through a serious problem?*

**Assess functioning and coping.** Through observing, asking questions, and understanding the survivor's past and current problems/losses, develop an impression of the survivor's ability to address challenges. Based on this assessment, consider making referrals, pointing out coping strengths, and encouraging the survivor to seek support. Ask the survivor:

- *How are you doing?*
- *How do you feel about how you are coping with this?*

- *How have you coped with stressful life events in the past?*

**Provide reassurance, normalization, psychoeducation, and practical assistance.** Reassurance and normalization of feelings and reactions occur throughout the intervention. It is extremely important that the survivor feels that the response received is personal. Pay close attention to his/her experience and style, and do not offer "canned" responses. Psychoeducation should address the particular reactions mentioned by the survivor and may provide additional information through a pamphlet or individualized information. A sample statement might be:

- *The way you're feeling is normal.*

## *Informational Briefing*[13]

Survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. Disaster mental health workers do not provide informational briefings, but they may consult officials about the need to do so and offer to be present to provide support, as needed. They may also encourage officials to ensure that cultural and ethnic groups have access to these briefings. Also, they may offer suggestions to officials about:

- Appropriate language/terminology
- Level of detail for sensitive information
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

For more on communicating during a crisis, see Module 5.

## *Psychological Debriefing*[14]

Psychological debriefing is a group intervention that has been used with a wide range of groups, including emergency responders, highly exposed survivors, community bystanders, and groups from the larger affected community. It involves a series of stages that move participants from a more cognitive consideration of the traumatic event, to discussion and expression of emotions and reactions, and then back to more cognitively focused learning about coping and problem-solving.

Components of psychological debriefing include:

- The facilitator introduces the process and ground rules
- The participants describe the stories of their involvement with the event

[13] Ibid.
[14] Ibid.

- The participants describe their thoughts, feelings, and reactions during and since the event
- The facilitator validates and normalizes reactions, and provides psychoeducation
- The facilitator wraps up the session by addressing issues, distributing brochures on stress and coping, and discussing when and how to seek professional help

Facilitation of an effective psychological debriefing requires more clinical skill than simply knowing and following the steps. Specific training for conducting these group interventions, as well as partnering and supervision with an experienced facilitator, is strongly recommended.

Participation in a debriefing should be completely voluntary and follow up is necessary—the debriefing should not be an intervention in isolation but one element of a comprehensive and sustained support program.

Ensure that the group is composed of persons linked socially via working relationships or prior friendships rather than merely grouped by geographical proximity at the time of the scheduled debriefing. Reduce individual isolation and foster group cohesion with an open and frank discussion among care providers or persons concerned with the well-being of participants. Focus on "what happened" by creating a cognitive historical narrative of the event. Participants should be allowed to express their feelings, if they choose, and those feelings should be supported. *Any attempt to extract the real or underlying emotions is strongly discouraged.* Those with prior abusive experience, minimal ability to regulate affect, limited ego-functioning, or serious preexisting mental illness may be harmed by being forced to participate in highly emotional, mandatory debriefings.[15]

It is recognized that, at the time of this writing, the literature reflects ambiguous results regarding the effectiveness of this particular modality.

## *Psychoeducation*[16]

Psychoeducation for survivors, health care providers, and providers of community services is a core component of mental health response. Information is typically provided about:

- Post-trauma reactions, including "normal reactions to abnormal situations"
- Grief and bereavement
- Effective coping strategies
- Indications of when to seek professional help

[15] Lacy, T.J. and Benedek, D.M. (2003, May). Terrorism and weapons of mass destruction: Managing the behavioral reaction in primary care. Southern Medical Journal. 96(5):394-399.
[16] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Material should be specifically oriented to the actual event and locale, as well as adapted for each group or population so that it is age-appropriate and culturally appropriate. All forms of the media are used to disseminate information. Psychoeducation should be based on the survivor's presenting concerns.

Educational presentations are offered to schools, senior centers, community and recreation centers, faith organizations, and at many other community events. Parents, teachers, and caregivers often ask questions on how they can best help children. Help them recognize reactions of children in various age groups and provide them with strategies to help the children cope.

## *Community Outreach*[17]

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Within hours of the event, survivors and their families may be geographically dispersed. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach.

The sniper incidents the year after the terrorist attacks, for example, heightened the fear already felt by many Northern Virginia residents. Community outreach was a key service during this period because the public was eager for support and information on how to cope. An outreach team from the Alexandria Community Resilience Project (CRP) distributed the "Coping with Sniper Attacks" brochure at area gas stations, strip malls, and other locations. Community members who received the brochure were thankful, and many shared their feelings and reactions with project staff.

Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors through the media, the Internet, and maintaining 24-hour telephone hotlines with responders who speak different languages
- Participating in or conducting meetings for preexisting groups through faith communities, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers

*We conducted a lot of classes for a whole variety of different organizations, businesses, churches, [and] schools on stress management. So we provided a lot of stress management and, from that, it was really interesting how we were able to draw people that needed the help, and refer them, and actually even get into other areas and communities that needed the help we could provide.*

June Eddinger
Project Director, Loudoun County
Community Resilience Project

[17] Ibid.

Community outreach requires:

- Ability to initiate conversations with those who have not requested services
- Good interpersonal skills
- Ability to quickly establish rapport, trust, and credibility
- Ability to think on one's feet
- A sense of diplomacy
- Knowledge and respect of values and practices of cultural groups affected by the event

**Reaching the Unemployed**

Unemployment in Northern Virginia increased due to the post-9/11 economic downturn. Employers in the area, including those in the travel and tourism business, imposed layoffs that created added stress for many residents. To reach these workers and offer emotional support and referral assistance, CRP counselors went to local job centers and state unemployment offices.

In Fairfax County, CRP staff kept regular hours at an apartment complex inhabited by many service and travel industry workers. The community, which has a history of crime, domestic violence, and racial tensions, was hard hit by the 9/11-related loss of jobs at nearby Dulles Airport. CRP staff focused on one-on-one counseling and participated in employment fairs and referrals.

Community outreach efforts may include:

- *Community memorial and commemorative events.* A disaster mental health worker may help with the planning of community memorial and commemorative events. It is critical that the role is that of a consultant rather than a director. Survivor and community ownership of the event enhances its meaning and significance. A disaster mental health worker may:
  - Suggest strategies for including children or other special survivor groups
  - Alert planners to the potential for misunderstanding or for alienating survivors or groups through the use of particular language or symbols
  - Attend these events and be available to provide psychological support as needed and requested
- *Usual community gatherings.* Continuation of usual gatherings or events, such as community parades, school plays, or church fairs, promotes hope and the sense that the community can overcome harm and recover. Decisions to cancel or postpone these events must be made carefully, as they provide valuable opportunities for social support and healing. A disaster mental health worker may:
  - Assist community leaders in determining whether to hold an event

  - Offer suggestions for ways to adapt the event so that it appropriately acknowledges the community tragedy

- *Symbolic gestures.* Symbols can have profound significance for people who wish to communicate gratitude and good will or who are searching to find meaning, courage, and hope. Simple gestures can become powerful conveyors of compassion and condolence. A disaster mental health worker may:

  - Assist affected groups to develop symbols

  - Provide assistance with the logistics to carry out an idea

- *Materials and activities targeted toward different populations.* Members of different populations, including different age and racial/ethnic groups, exhibit varied reactions to tragic events. To tailor a mental health response to their backgrounds and needs, a disaster mental health worker may:

  - Form a multicultural outreach team to distribute information in the community and make presentations

  - Develop brochures in multiple languages and distribute them in locations frequented by different groups, e.g., neighborhood gas stations, grocery stores, strip malls, libraries, schools, and other public areas

*Experience is always the best teacher. 9/11 has been a unique experience. Even in the Oklahoma City disaster, it was a different kind of situation. It was a one-time event by people who were later captured and put in jail. The 9/11 experience was not just an event, but it started a process which has had other incidents and also has had a different climate attached to it. We didn't know that there were going to be all these other events. We didn't quite anticipate the complexity of the dynamics of our community, in terms of having so many different groups, particularly ethnic groups who have come here relatively recently and who were so acutely and intensely affected by the events themselves, and [who have] an ongoing sense of vulnerability to further attack… We had to do a lot of customizing of the services that we've provided, changing the venues, the content of our presentations, and providing staff who were familiar to the community with which they worked.*

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

- Conduct life skills workshops with topics on stress management and how to cope with reactivated fears from survivors' experiences in their native countries
- Conduct cross-cultural dialogues
- Provide life skills training for youth at recreation centers, family resource centers, and juvenile detention/post-detention facilities
- Work with youth to write and produce plays or other creative activities based on their experiences and feelings

*There was one man at the airport…We had come out to the airport several times [to give classes on stress management], but he came to us afterwards and said that the information that we had given him was actually life-changing, that it had helped him calm down. It helped to put things into perspective. A lot of the stress management techniques that we taught people were really, really helpful and were exactly what they needed.*

June Eddinger
Project Director, Loudoun County
Community Resilience Project

*We do a lot of work in neighborhoods with teens, working on issues about anger management and where anger comes from, like using anger to work out our stress and our fear. And so one of the things that is really a focus of our anger work is to help teens tap into sources of that fear and to talk in very safe and comfortable ways, with folks that speak their language, about more positive ways to work out those feelings.*

Shauna Spencer, M.B.A., C.P.H.Q.
Project Director
Project DC

**Outreach Can Happen Anywhere, Anytime**

The cumulative stress of all that has happened here in Northern Virginia is demonstrated in how people relate with one another within the community. The following describes an experience of an Arlington County CRP outreach worker and demonstrates that treatment, although important, is only one element of a mental health response to terrorism. Community healing is as important as treatment. Outreach workers can be of assistance in a formal way or on the spur of the moment.

*Publicly distributing pamphlets about Islam in front of a subway station can mean exposing oneself to the possibility of persecution—especially in one of the counties where the deadliest terrorist attack in United States history took place. The pain is still fresh, the suffering continues, and many believe Islam is to blame, yet this man was suffering too. In my role as an Outreach Counselor for the Arlington CRP, I gladly accepted one of his pamphlets and gave him one of ours. Anxiety was evident in his voice and his eyes as he began speaking urgently to me of the peaceful nature of his religion, as though he longed to announce to the whole world that he is neither guilty nor responsible for this tragedy. Tension rose as we were approached by another man, who loudly and unabashedly expressed anger at those who use religion to "mess up the world." I relied on the crisis counseling training I had received to listen supportively and understand the root of his anger. The anger turned to sadness as he spoke of the horrors he had suffered as a soldier in Vietnam. Slowly, the initial conflict between the two men began to melt away, as they both expressed a hatred of the suffering caused by war, a solidarity for both having experienced it personally, and an appreciation for those who dedicate their lives to ease the pain of others. I watched them exchange a handshake and words of respect. They each left with a CRP brochure, a renewed sense of good will, and the knowledge that support is available. I left with an admiration of the inner strength of the people of this community, satisfaction that doing my job had met the important need of helping them find that strength, and an even greater pride that I call this place home.*

## *Brief Counseling Interventions*[18]

The therapeutic goals of brief counseling interventions involve the following:

*With the sniper event, we had a lot of parents calling in saying, "How I do talk to my children about this?" "How do I reassure them?" "What can I do?" "Do you have information for me?" For some of them, we would do brief crisis counseling. With others, we just sent materials; they felt that was all they needed, just some tools.*

June Eddinger
Project Director, Loudoun County
Community Resilience Project

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event
- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

The most therapeutic approaches recognize that the survivor's capacity to confront painful realities and intense emotions develops gradually; therefore, the treatment process must move at a rate that is comfortable to the survivor.

[18] Ibid.

Counseling may use a particular treatment approach or be multi-modal and incorporate a combination of different approaches. Treatments commonly used for post-traumatic stress and traumatic bereavement include:

- Cognitive-behavioral therapy
- Phase-oriented treatment
- Bereavement counseling
- Eye movement desensitization and reprocessing
- Brief therapies
- Psychopharmacology

These modalities have varying levels of scientific evidence supporting their efficacy. Many mental health professionals attempt to match the treatment approach with its perceived acceptability and helpfulness to the client.

**Creative Approaches to Connecting with Community Members**

Mental health outreach workers are encouraged to initiate strategies that make it easy and comfortable for community members to tell their stories, such as:

- Attendance at workshops for people who are seeking financial assistance demonstrates an active interest in the reality of their situation. Individuals are likely to accept this kind of help before they will talk about their personal feelings. When offering this level of help, the disaster mental health worker will quickly discover that survivors readily begin talking about their experience.
- Project Liberty, a program established in New York City to provide free crisis counseling services to those affected by 9/11, found that the following interventions created additional opportunities to reach survivors:
  - **Online or "Intherapy" interventions.** Interventions provided through the Internet were particularly effective with youth audiences as well as with Project Liberty and EMS workers who preferred anonymity.
  - **Phone interventions.** Phone interventions helped improve access to those unable to leave their homes.

## *Support and Therapy Groups*[19]

Group treatment is especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance, is another important function of support groups.

[19] Ibid.

Groups may be offered for parents, children, members of a particular neighborhood, a particularly affected occupational group (such as the airline industry after 9/11), or survivors who suffered a particular trauma or loss (e.g., bereaved parents).

Grief counseling is an important component of group services. The Community Resilience Project found some victims were not ready to participate in grief groups early on. Family members were instrumental in encouraging others to participant in grief groups.

Community Resilience Project staff were invited to participate as counselors at a weekend-long grief camp for children who had lost parents due to 9/11 or other causes. Without exception, each staff member who provided services reported the camp was one of their most rewarding Project and grief-work experiences.

It is recommended that groups be facilitated by an experienced mental health professional, ideally with a cofacilitator, and be time-limited, with expectations defined at the outset.

*Grief groups provide a supportive forum for people to discuss their reactions to loss. You have a group of individuals all of whom have something in common—which is having lost somebody dear to them. It doesn't have to be a family member; it can be a colleague or a friend…They might not know each other when the group begins. There were some people from New York that were also in our groups. The mutual support and trust that the group members build helps the process of renormalization of their lives as they discuss trying to put things back together again. The children have groups of their own, and they're able to express themselves in various creative ways, through artistic and other expressive methodologies. In all of these groups, feelings that would otherwise stay bottled up and might cause serious difficulties later on are brought to the surface in a timely manner. There's the feeling that I'm not alone in this. There are other people who are suffering too. They're still working. They're still getting by. Therefore, I can do it too. Align background*

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

## Mental Health Consultation[20]

Mental health professionals may be brought into decision-making and planning teams to advise public officials and community leaders about mental health issues. Public officials may seek mental health consultation on a variety of issues, such as mental health support, leave for rescue and recovery workers, and rituals or memorials for honoring the dead. To function effectively in this consulting role, disaster mental health workers must be well versed in emergency and criminal response protocols as well as the responding agencies' roles and priorities.

[20] Ibid.

## *Death Notification*[21]

Mental health professionals may have an immediate support role with bereaved families and loved ones during and after a formal death notification. Mental health professionals typically do not deliver the death notification but rather accompany the persons responsible for the notification. Mental health professionals may:

- Provide support and mental health consultation to the family receiving the news
- When requested, provide support and mental health consultation to those conducting the notifications
- Provide, to those responsible for the notification, information on specific cultural or ethnic customs regarding the expression of grief as well as rituals surrounding death and burial

**Death Notification Procedure**

Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates. The curriculum is summarized below:

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.
2. Notify in person. Do not call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.
3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and/or trained in CPR/medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.
4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.
5. Present credentials and ask to come in.
6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.
7. Use the victim's name... "Are you the parents of _____?"
8. Inform simply and directly with warmth and compassion.
9. Do not use expressions like "expired," "passed away," or "we've lost _____."
10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "[Name] has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important, because it expresses feelings rather than facts and invites them to express their own.
11. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body" or "the deceased."
12. Do not blame the victim in any way for what happened, even though he/she may have been fully or partially at fault.
13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock, have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.

[21] Ibid.

14. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, and express concern. *Examples:* "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."
15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.
16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.
17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.
18. Do not speak to the media without the family's permission.
19. If identification of the body is necessary, transport next of kin to and from the morgue, and help prepare them by giving a physical description of the morgue and telling them that [Name] will look pale because blood settles to the gravitational lowest point.
20. Do not leave survivors alone. Arrange for someone to come, and wait until they arrive before leaving.
21. When leaving, let the persons know you will check back the next day to see how they are doing and if there is anything else you can do for them.
22. Call and visit again the next day. If the family does not want you to come, spend some time on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.
23. Ask the family if they are ready to receive [Name's] clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.
24. If there is anything positive to say about the last moments, share them now. Give assurances, such as "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, "s(he) did not know what hit them" unless you are absolutely sure.
25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.
26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.
27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis. Do not try to carry the emotional pain all by yourself, and do not let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

## Summary

The real purpose behind a terrorist event is to create fear within the community. Providing good mental health services to survivors of a terrorist event requires a thorough understanding of common and more problematic reactions to such events. In addition to responding to the post-traumatic reactions, mental health workers may also be addressing ongoing fear. Service decisions must be guided by the key principles of disaster mental health intervention. The list of intervention approaches is provided in this module to help mental health providers understand the range of services that may be appropriate following a terrorist event. Ultimately, it will be up to each mental health service provider to learn from this guidance and, in the event of a terrorist attack, to use his/her experience and professional intuition to make the best decisions.

## Additional Resources

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, http://www.mentalhealth.org/cmhs/.

DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Center for Mental Health Services. (Unpublished). Design and implementation of disaster mental health services: A handbook for mental health professionals. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Israel Trauma Center for Victims of Terror and War, http://www.natal.org.il.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs, http://www.ncptsd.org/publications/disaster/index.html.